STATE HEALTH BENEFIT PLAN
TOBACCO CESSATION PROGRAM AFFIDAVIT FORM
ALL OPTIONS EXCEPT KAISER PERMANENTE HMO MEMBERS

Policyholder/Plan Member Name_____

Social Security Number_____

Tobacco Cessation Program _____

I hereby certify that all covered members have not used any tobacco products in the last 60 days. In addition, I have attached a certificate of attendance affirming that each dependent that previously used tobacco has completed **all** classes in a State Health Benefit Plan approved tobacco cessation program.

I also understand that this document must be completed and returned to my payroll benefit coordinator in order for re-evaluation of the tobacco surcharge currently being applied to my health coverage premium. In addition, if I or any covered dependents resume using any tobacco products after attending these classes I will complete the necessary document to notify the Plan. Any change will be effective relative to the payroll schedule for my employer. No refund in premium will be made for the previous deductions that included the surcharge amounts. IRS rules require all premium charges to be prospective.

Signature_____ Date_____

Note: Once you have read and signed this affidavit, you must submit it to your payroll location/benefit coordinator to have the required deduction information completed below.

Department/School System Use Only		
Payroll Location #	***Date of first deduction**	**Deduction Amount**

***Retro deductions will NOT be granted.**